

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4202SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/01/2010
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR OF FALLON			STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH SHERMAN ROAD FALLON, NV 89406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{Z 000}	<p>Initial Comments</p> <p>Surveyor: 13812</p> <p>Surveyor: 22046</p> <p>This Statement of Deficiencies was generated as a result of a State licensure resurvey conducted in your facility on 1/25/10 and finalized on 2/1/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. The resurvey was conducted in response to the findings of the complaint survey (Complaint #NV00023190) on 11/13/09.</p> <p>No regulatory deficiencies were identified.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	{Z 000}			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE